BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	File No. 09-2004-156433
BHARATI GHOSH, M.D.	OAH No. L2006070130
Physician's and Surgeon's Certificate No. A 34230	
Respondent.	

DECISION

The Proposed Decision of Humberto Flores, Administrative Law Judge, dated January 4, 2007, in Los Angeles, is attached hereto. Said decision is hereby amended, pursuant to Government Code Section 11517 (c)(2)(C) to correct technical or minor changes that do not affect the factual or legal basis of the proposed decision. The proposed decision is amended as follows:

1. Page 6 - the patient's name "Antonio D." is corrected to read, "Antonio G."

2. Page 7, Legal Conclusion No. 2 - Business and Professions Code section "2434, subdivision (c)" is corrected to read "2234, subdivision (c)."

3. Page 8, Legal Conclusion No. 3 - the Business and Professions Code section "2434, subdivision (d)" is corrected to read "2234, subdivision (d)."

4. Page 2 - "PHVMC" is corrected to read "PVHMC."

The Proposed Decision as amended is hereby accepted and adopted as the Decision and Order by the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 28, 2007.

DATED January 29, 2007

MEDICAL BOARD OF CALIFORNIA

By: Cesar A. Aristeiguieta, MD

Cesar A. Aristeiguieta, M.D., Chair
Panel A
Division of Medical Quality

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: BHARATI GHOSH, M.D., 9645 Monte Vista #304 Montclair, California 91763 Physician and Surgeon's Certificate No. A 34230 Respondent.	Case No. 09-2004-156433 OAH No. L2006070130

PROPOSED DECISION

This matter was heard by Humberto Flores, Administrative Law Judge, Office of Administrative Hearings, on November 13 through 16, 2006, in Los Angeles, California.

Deputy Attorney General Mary Agnes Matyszewski represented complainant.

Phillip S. Cifarelli, Attorney at Law, represented Bharati Ghosh, M.D. (respondent) who was present during the hearing.

Evidence was received and the record was left open to allow complainant to submit transcripts of taped interviews of respondent conducted by a Medical Board investigator and a district medical consultant. The transcripts were received on November 30, 2006. Respondent's counsel stated at the hearing that respondent did not object to the admission of said transcripts. The Administrative Law Judge reviewed the transcripts on December 4, 2006, and marked and admitted the transcripts as exhibit 20. The record was closed and the matter was deemed submitted on December 4, 2006. The Administrative Law Judge finds as follows:

FACTUAL FINDINGS

1. On September 16, 2005, David T. Thorton made and filed the Accusation in his official capacity as Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On August 3, 1979, the Medical Board of California issued Physician and Surgeon's Certificate No. A 34230 to respondent. The certificate was in full force and effect at all times relevant to the Accusation.

PATIENT KEVIN B.

3. On June 1, 2002, patient Kevin B., then a 13-month-old child, first presented to respondent at Montclair Hospital emergency room (ER) with a one week history of vomiting and diarrhea. Respondent had Kevin B. transferred to Pomona Valley Hospital Medical Center (PVHMC) because he needed increased pediatric care. The patient was admitted at 5:00 p.m., and nursing notes state that the patient was "lethargic – minimally responsive to painful stimuli . . ." Respondent was at PHVMC at the time of admission and ordered intravenous normal saline (bolus).

4. Respondent examined the patient at PVHMC, took vital signs, and noted in the admission history that the patient was "lethargic but arousable," had dry lips, no teardrops, sticky oral mucosa, a soft distended abdomen, fair skin turgor and equal bilateral pulses. Respondent's admission assessment was (1) left otitis media, (2) acute gastroenteritis, (3) moderate dehydration, (4) abdominal ileus, and (5) rule out acute abdomen. Respondent ordered lab tests, which showed that the patient had severe hyponatremia[1] and severe metabolic acidosis both of which are suggestive of septic shock, however, these lab results were not addressed in respondent's admission notes. The patient also had elevated liver function tests.

5. At 5:30 p.m., the attending nurse suggested to respondent that the patient should be transferred to PICU (pediatric intensive care unit). Respondent replied that she would manage the patient herself for the time being. At 6:15 p.m., the patient was moved to a room near the nurse's desk for closer observation. At 8:30 p.m., the patient was noted to be febrile and was given Tylenol.

6. Respondent was at or near the patient's bedside until approximately 9:00 p.m. At 10:00 p.m., the attending nurse noted that the patient was tachycardic, tachypneic, remained febrile, and notified respondent of the patient's condition. At 10:30 p.m., the attending nurse noted poor urine output and orange colored mucous stool and sent specimens to the lab. At approximately 11:00 p.m., the attending nurse notified respondent of lab results and of the patient's "unchanged status." This nurse also requested that respondent transfer the patient to PICU. Respondent declined to transfer the patient at that time and told the nurse that she (respondent) would be in early the next morning. Respondent also ordered a transfusion of fresh frozen plasma (FFP).

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[1] Hyponatremia is a sodium deficiency.

7. On June 2, 2002, at 12:10 A.M., the attending nurse noted that the patient remained tachycardic, with a respiratory rate in the 50s. At 1:00 a.m., the nurse notified respondent of the patient's low urine output and noted "MD to transfer child to PICU in AM." At 1:10 a.m., the patient was still tachycardic, with a blood pressure of 70/41. The FFP transfusion was started. At 1:45 a.m., the nurse informed respondent that the patient's status was not improving, and wrote in her nursing notes that "Dr. Ghosh to call Dr. Mandi for pt (patient) transfer to PICU." The patient was finally transferred to PICU at 2:45 a.m.

8. The standard of care in the admission of a child in Kevin B.'s condition is to examine the child, make an assessment, and determine the level of care needed for the patient. In this case, the patient was lethargic and in compensated septic shock at the time he was admitted to PVHMC, but respondent did not include shock in her assessment of the patient. Further, respondent failed to document that the patient was in metabolic acidosis, had severe hyponatremia, was tachypneic, or tachycardic. Respondent's failure to properly address and/or document all of the conditions set forth above was an extreme departure from the standard of care and demonstrated incompetence.

9. Based on the condition of this child, respondent should have transferred the patient to the pediatric intensive care unit much earlier than she did. The PICU has more technology available for patient care, provides constant monitoring of vital signs, has a higher nurse to patient ratio, and has a Board Certified intensivist available for patients. The patient was at PVHMC for approximately nine hours before respondent gave the order to transfer the patient to the PICU. Respondent's failure to transfer the patient to the pediatric intensive care unit within a reasonable time was an extreme departure from the standard of care, and demonstrated incompetence.

PATIENT PETE J.

10. On June 28, 2003, patient Pete J. was a six-year-old boy who presented to the Montclair Hospital emergency room with breathing problems over the previous 24 hours. The patient was diagnosed with urinary tract infection, was treated with Zithromax, given a prescription and released. The parents called respondent several times during the night, and at midnight the parents informed respondent that the child's respiratory condition had deteriorated.

11. On June 29, 2003, respondent told the parents to return to the Montclair Hospital ER where the patient was reevaluated. He was stridorous initially but this condition resolved. A chest x-ray revealed bilateral pneumonia. A decision to admit the patient was made but Montclair Hospital did not have an available bed so respondent ordered the patient transferred to PVHMC where respondent resumed care of the patient.

12. Upon arrival at PVHMC, respondent examined the patient. Respondent noted in the history and physical report that the patient had a history of chronic allergies. Respondent examined the patient and noted in her report that the patient's "lungs were clear to auscultation and percussion at this time."

13. Respondent assessed the patient with "1. Acute rhinitis causing a condition similar to adult chronic obstructive pulmonary disease without smoke exposure. 2. Adenoiditis. 3. Urinary Tract Infection. 4. Family obesity." Respondent's plan included Oxygen as required; intravenous piggy-back Clafloran 900 milligrams every six hours; Albuterol nebulizer; and racemic epinephrine for stridor. Respondent also started the patient on Decadron. After examining the patient, respondent unsuccessfully attempted to have an ENT consultation.

14. Respondent incorrectly diagnosed the patient with "acute rhinitis causing a condition similar to adult chronic obstructive pulmonary disease." This diagnosis was not consistent with the symptoms exhibited by the patient, which included stridor and snoring. Further, respondent failed to include a diagnosis of pneumonia in her assessment of the patient. Respondent, who had been the patient's physician for five years, testified that she had been told of the x-ray that showed bilateral pneumonia, but she listened to the patient's lungs and determined that it was not active pneumonia and ruled it out. This testimony is inconsistent with respondent's statements in her January 18, 2005 interview conducted by the Board representatives. In any event, respondent should have included pneumonia in her assessment of the patient and document that she ruled it out. Respondent's failure to properly assess and diagnose the patient was an extreme departure from the standard of care and demonstrated incompetence.

15. Complainant asserts that respondent's orders for racemic epinephrine, albuterol and steroids that were not indicated for this patient. Complainant's assertion is not persuasive. Racemic epinephrine is indicated for stridor, and albuterol and steroids are appropriate prescriptions for asthma. Although respondent did not include asthma in her assessment or note asthma in her report, respondent's office medical records for this patient indicate a history of asthma (exhibit E, pages 0034 and 0060).

PATIENT ALEXIS J.

16. Patient Alexis J. was a five-year-old female who was admitted to PVHMC December 13, 2003. She initially presented to respondent with complaints of "respiratory distress for a few day, deteriorating." Respondent examined the patient and noted "bilateral rales and wheezes and a decision to admit was made." Respondent's assessment was (1) acute exacerbation of chronic allergic asthma; (2) serious otitis media; and (3) severe allergic rhinitis. Respondent prescribed albuterol syrup, albuterol inhaler and albuterol for nebulization. These are three different forms of the same medication.

17. None of the orders for albuterol were written as PRN (as needed) orders. There was no basis to order all three forms of albuterol for this patient. Complainant's experts agreed that respondent's orders for albuterol were below the standard of care. However, these experts did not agree on whether this was an extreme or simple departure from the standard of care. Therefore, this is deemed a simple departure.

18. Respondent's admission report does not document whether the patient was on albuterol at home; whether she had a fever; and/or whether she had flaring or retractions. Further, respondent did not note in the admission report the patient's respiratory rate and oxygen saturation rates. Respondent had no justification to admit the patient or failed to document justification for admission. This was an extreme departure from the standard of care.

PATIENT JESSICA Q.

19. Jessica Q. was a 14-month-old female patient who was admitted to PVHMC on April 15, 2003, for acute gastroenteritis. Respondent's admission history and physical states that respondent examined the patient the pervious day and determined that the patient suffered from otitis media and was given antibiotics. According to the patient's mother, Jessica Q. would spit out the antibiotics. Respondent noted "since the child was lethargic, the decision to admit was made." Respondent's admission assessment included: (1) Acute gastroenteritis; (2) Dehydration 3% to 5% secondary to above; (3) Otitis media bilateral; and (4) Rule out sepsis."

20. During the hospitalization, the patient was given IV fluids and IV Claforan. The patient was discharged on April 18, 2003. Respondent's discharge diagnosis included: "(1) Gastroenteritis, resolved; (2) Dehydration, resolved; and (3) Sinusitis with Hemophilius species which probably resolved into the gastroenteritis."

21. Respondent failed to document a toncillar examination on patient Jessica Q. Further, respondent recorded an incorrect discharge diagnosis of "Sinusitis with Hemophilius species which probably resolved into gastroenteritis." Respondent testified that this entry was an obvious transcribing error that she missed at the time she reviewed and signed the Discharge Summary Report. Respondent asserted that it should have read "Pharyngitis with Hemophilius species which probably resolved along with gastroenteritis." Respondent failed to properly review and correct the Discharge Summary Report. Respondent's documentation errors were simple departures from the standard of care.

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PATIENT VANESSA M.

22. September 1, 2000, patient Vanessa M., then a 29-day-old female, presented to respondent at Global Medical Center (GMC), Montclair, California, following her transfer from the Chino Hospital emergency room with a differential diagnosis of "rule out sepsis." A septic work up had been completed the Chino Hospital ER where attending physicians gave the patient Ampicillin and Gentamicin. Upon transfer to GMC, respondent ordered a change in antibiotics to Claforan (Cefotaxim) at a dose of 50mg/kg/day. However, the suggested dose for an infant one to four weeks of age is 150mg/kg/day. Respondent's failure to order the proper dosage of Claforan was a simple departure from the standard of care.

PATIENT ANTONIO G.

23. Patient Antonio D. was admitted to PVHMC on January 5, 2002. The patient was a 16-year-old male with cerebral palsy and spastic quadriplegia. The patient had complained of not feeling well and of decreased urine output two days prior to admission. The patient's mother informed respondent that the patient had decreased temperature and poor verbal response. Respondent advised hospitalization.

24. Respondent's assessment on admission included: "(1) Cerebral palsy with spastic quadriplegia; (2) Urinary tract infection; and (3) possible sepsis." One hour after admission, the patient went into respiratory distress and a code blue was called. Respondent quickly responded to assess the situation. The patient was stabilized.

25. Respondent failed to document the patient's current medications, and failed to consider or document an evaluation of laboratory results showing extreme anemia and thrombocytopenia.(decrease in the number of blood platelets). This lack of documentation was a simple departure from the standard of care.

PATIENT BABY GIRL V.

26. Baby Girl V. was born PVHMC on December 31, 2003, 1:02 p.m., via normal vaginal delivery. The patient's mother had blood type O positive, and the baby's blood was type A. Complainant alleges that respondent failed to note or document whether the patient was jaundiced, and that respondent discharged the patient without instructions to the parents to return for a follow-up examine within 24 to 48 hours. Complainant did not establish facts to support these allegations. Respondent was aware of the patient's ABO blood incompatibility, examined for and found no evidence of jaundice. Further, it was not necessary in this case to have the patient return 24 to 48 hours after discharge because the baby remained in the hospital 48 hours after birth, and respondent examined the baby prior to discharge.

RESPONDENT'S EXPERIENCE AND EDUCATION

27. Respondent has been licensed to practice medicine since 1979. She obtained her degree in medicine in 1972 from the University of Calcutta, Calcutta, India. Respondent has significant experience in pediatrics and provides medical care for an underserved population. She was certified by the American Board of Pediatrics in 1985 and recertified in 1995. Respondent is Chairperson of the Department of Pediatrics, Montclair Hospital Medical Center, in Montclair, California. Respondent is also Chairperson of the Bioethics Committee for the same hospital. She is also an Adjunct Associate Professor at Western University Health Sciences, Pomona, California, and is the Pediatric Advisor for the Pomona Unified School District and for the San Gabriel Valley Health Services Advisory Council. Finally, it is noted that for the past ten years, respondent has voluntarily provided services at various health fairs in Los Angeles County.

PRIOR DISCIPLINARY ACTION

28. On October 16, 1994, in a prior disciplinary action (Case No. 07-1990-004011), the Board revoked respondent's certificate, stayed the revocation and placed respondent on probation for five years on certain conditions. The discipline was based on violations of Business and Professions Code sections 2234, subdivision (c), repeated acts of negligence, and 2234, subdivision (e), and act of dishonesty. Respondent completed all terms and conditions of this probation.

COSTS OF INVESTIGATION AND ENFORCEMENT

29. Complainant requested that respondent be ordered to pay reasonable costs of investigation and enforcement pursuant to Business and Professions Code section 125.3. However, complainant did not present evidence to support this request.

LEGAL CONCLUSIONS

1. Cause exists to suspend or revoke respondent's physician and surgeon's certificate for gross negligence under Business and Professions Code section 2234, subdivision (b), based on set forth in Factual Findings 3 through 14, and Factual Finding18.

2. Cause exists to suspend or revoke respondent's physician and surgeon's certificate for unprofessional conduct under Business and Professions Code section 2434, subdivision (c), based on Factual Findings 3 through 23.

3. Cause exists to suspend or revoke respondent's physician and surgeon's certificate for unprofessional conduct under Business and Professions Code section 2434, subdivision (d), based on Factual Findings 3 through 14.

4. Cause exists to suspend or revoke respondent's physician and surgeon's certificate for unprofessional conduct under Business and Professions Code section 2266, based on Factual Findings 3 through 14, 18, 19 through 21, and 23 through 25.

5. Cause does not exist to suspend or revoke respondent's physician and surgeon's certificate for unprofessional conduct under Business and Professions Code section 2234, subdivisions (c), based on Factual Finding 26.

6. Cause does not exist to order respondent to pay costs of investigation and enforcement under Business and Professions Code section 125.3, based on Factual Finding 29.

ORDER

Certificate No. A 34230, issued to respondent Bharati Ghosh, M.D., is revoked pursuant to Legal Conclusions 1through 4. However, the revocation is stayed and respondent is placed on probation for seven (7) years upon the following terms and conditions:

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Division or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California, San Diego School of Medicine (Program).

The program shall consist of a Comprehensive assessment program comprised of a two day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clincians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at a minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision, Accusation and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendations(s) for the scope and length of any additional education or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the Program recommendations.

At the completion of any additional educational and clinical training, respondent shall submit to and pass an examination. The Program's determination of whether or not respondent passed the examination or successfully completed the program shall be binding.

Respondent shall complete the Program not later than six (6) months after respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

If respondent fails to complete the clinical training program within the designated time period, respondent shall cease the practice of medicine within 72 hours after being notified by the Division or its designee that respondent failed to complete the clinical training program.

3. Monitoring - Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Division or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice and billing shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor(s) shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine and whether respondent is practicing medicine safely.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

4. Notification

Prior to engaging in the practice of medicine the respondent shall provide a true copy of the Decision Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

6. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

7. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. Probation Unit Compliance

Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

9. Interview with Division or its Designee

Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

10. Residing or Practicing Out-of-State

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

11. Failure to Practice Medicine – California Resident

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non- practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the

responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

12. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon completion successful of probation, respondent's certificate shall be fully restored.

13. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action.

If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

15. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

DATED: January 4, 2007

Humberto Flores

HUMBERTO FLORES
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: BHARATI GHOSH, M.D. 9645 Monte Vista Ave., #304 Montclair, CA 91763 Physician's and Surgeon's Certificate No. A 34230 Respondent.	Case No. 09-2004-156433 OAH No. **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. David T. Thornton (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about August 3, 1979, the Medical Board of California issued Physician's and Surgeon's Certificate No. A 34230 to BHARATI GHOSH, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2007, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Division of Medical Quality (Division) for the Medical Board of California, Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

5. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's

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conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) . . . .

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Section 125.3 of the Code provides, in pertinent part, that the Division may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

8. Section 14124.12 of the Welfare and Institutions Code states, in pertinent part:

"(a) Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the

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department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent is subject to disciplinary action under Code section 2234(b) in that she was grossly negligent in connection with the care, treatment and management of the patients set forth in this paragraph. The circumstances are set forth below.

Patient Kevin B.

10. On or about June 1, 2002, patient Kevin B., a then 13-month-old child, first presented to respondent in the Montclair Hospital emergency room. Respondent transferred Kevin to Pomona Valley Hospital Medical Center because he needed increased pediatric care. However, respondent failed to note or document that Kevin was suffering from compensated septic shock, metabolic acidosis, hypenatremia, tachypneia or tachycardia. In addition, once at Pomona Valley Hospital Medical Center, respondent failed to timely turn the patient over to the ICU team.

Patient Pete J.

11. On or about June 28, 2003, patient Pete J., a then six-year-old male, presented to Doctor's Hospital of Montclair with a complaint of a breathing problem for 24 hours. After a chest x-ray revealed bilateral pneumonia, Pete was transferred to respondent's care at Pomona Valley Hospital Medical Center. Respondent incorrectly diagnosed Pete as suffering from "Acute rhinitis causing a condition similar to adult chronic obstructive pulmonary disease without smoke exposure." In addition, respondent ordered treatment with racemic epinephrine, albuterol and steroids even though they were not medically indicated.

Patient Alexis J.

12. On or about December 13, 2003, patient Alexis J., a then five-year-old female and known patient of respondent's, presented with complaints of respiratory distress. Respondent's assessment was acute exacerbation of chronic allergic asthma, serious otitis media and severe allergic rhinitis. Respondent admitted Alexis to Pomona Valley Hospital Medical

Center even though there was no justification for admission or respondent failed to document justification for admission. In addition, respondent failed to determine or document whether Alexis was on any albuterol at home; whether she had a fever; whether she had flaring or retractions; and, what her respiratory and oxygen saturation rates were. In addition, respondent improperly ordered both nebulized albuterol and oral albuterol even though they should not have been used together. Finally, respondent incorrectly believed that albuterol was used for chronic control of asthma when, in fact, it is a rescue medication.

Patient Jessica Q.

13. On or about April 15, 2003, patient Jessica Q., a then 14-month-old female, was admitted by respondent to Pomona Valley Hospital Medical Center with a diagnosis of acute gastroenteritis. Respondent failed to perform or document a tonsillar examination. In addition, respondent incorrectly interpreted Jessica's throat culture as "sinusitis with Hemophilus" and recorded an incorrect discharge diagnosis of "Sinusitis with Haemophilis species which probably resolved into gastroenteritis."

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

14. Respondent is subject to further disciplinary action under Code section 2234(c) in that she was repeatedly negligent in connection with the care, treatment and management of the patients set forth in this paragraph. The circumstances are set forth below.

15. Paragraphs 10-13 are incorporated herein by reference as if fully set forth.

Patient Vanessa M.

16. On or about September 1, 2000, patient Vanessa M., a then 29-day-old female, first presented to respondent at Global Medical Center following her transfer from the Chino Emergency Room with a differential diagnosis of rule out sepsis. Even though a full septic work up had been done at Chino and even though the Chino physicians had put Vanessa on Ampicililin and Gentamicin, respondent changed Vanessa's antibiotic to an inappropriately low dose of Cefotxime.

Patient Antonio G.

17. On or about January 5, 2002, patient Antonio G., a then 16-year-old male with severe cerebral palsy and spastic quadriplegia who had been a long cared for patient of respondent's, was admitted by respondent to Pomona Valley Hospital Medical Center with complaints of not feeling well, decreased urine output, decreased response and decreased temperature. At admission, respondent failed to inquire about or document Antonio's current medications. In addition, respondent failed to consider or document an evaluation of lab results showing extreme anemia and thrombocytopenia.

Patient Baby Girl V.

18. On or about December 31, 2003, respondent attended vaginally-delivered newborn patient Baby Girl V. at Pomona Valley Hospital Medical Center. Baby Girl V. was blood type A and her mother was blood type O+. Despite this incompatibility, respondent failed to note or document whether Baby G. V. was jaundiced; failed to order a bilirubin test; and, discharged her without instruction to return for follow-up in 24 to 48 hours. In fact, respondent set the follow-up for one week.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

19. Respondent is subject to further disciplinary action under section 2234(d) in that she was incompetent in connection with her care and treatment of seven patients as set forth in paragraphs 10-13 and 16-18 above, which are incorporated herein by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

20. Respondent is subject to further disciplinary action under Code section 2266 in that she failed to maintain adequate and accurate medical records as set forth in paragraphs 10-13 and 16-18 above, which are incorporated herein by reference as if fully set forth.

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DISCIPLINE CONSIDERATIONS

21. To determine the degree of discipline, if any, to be imposed on respondent, Complainant alleges that on or about October 16, 1994, in a prior disciplinary action entitled "In the Matter of the Accusation Against Bharati Ghosh, M.D.," Board Case No. 07-1990-004011 (also designated as D-4011), respondent's license was revoked, with revocation stayed and five-year probation imposed on findings respondent had committed repeated acts of negligence and an act of dishonesty, in violation of Code sections 2234(c) and 2234(e), respectively. That decision is now final and is incorporated by reference as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 34230, issued to BHARATI GHOSH, M.D.;

2. Revoking, suspending or denying approval of BHARATI GHOSH, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering BHARATI GHOSH, M.D. to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring; and,

4. Taking such other and further action as deemed necessary and proper.

DATED: September 16, 2005

DAVID T. THORNTON
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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